

# **EXHIBIT A45**

# REPORTS

## Prospective Study of Talc Use and Ovarian Cancer

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**Background:** Perineal talc use has been associated with an increased risk of ovarian cancer in a number of case-control studies; however, this association remains controversial because of limited supporting biologic evidence and the potential for recall bias or selection bias in case-control studies. In this study, we conducted a prospective analysis of perineal talc use and the risk of ovarian cancer. **Methods:** The Nurses' Health Study is a prospective study of 121 700 female registered nurses in the United States who were aged 30–55 years at enrollment in 1976. Talc use was ascertained in 1982 by use of a self-administered questionnaire; after exclusions, 78 630 women formed the cohort for analysis. Three hundred seven epithelial ovarian cancers subsequently diagnosed in this cohort through June 1, 1996, were confirmed by medical record review and met inclusion criteria. Proportional hazards models by use of pooled logistic regression were used to derive relative risks (RRs) and 95% confidence intervals (CIs). **Results:** In 1982, 40.4% ( $n = 31\,789$ ) of the cohort reported ever using talc, and 14.5% ( $n = 11\,411$ ) reported ever using talc daily. We observed no overall association with ever talc use and epithelial ovarian cancer (multivariate RR = 1.09; 95% CI = 0.86–1.37) and no increase in risk of ovarian cancer with increasing frequency of use. There was a modest elevation in risk for ever talc use and invasive serous ovarian cancer (multivariate RR = 1.40; 95% CI = 1.02–1.91). The risk of epithelial ovarian cancer for talc users was not greater among women who had never had a tubal ligation (multivariate RR = 0.97; 95% CI = 0.71–1.32). **Conclusion:** Our results provide little support for any substantial association between perineal talc use and ovarian cancer risk

overall; however, perineal talc use may modestly increase the risk of invasive serous ovarian cancer. [J Natl Cancer Inst 2000;92:249–52]

Talc was originally implicated as a possible ovarian carcinogen because of its chemical similarity to asbestos, which has been linked to ovarian cancer in occupational settings and is associated with mesotheliomas histologically resembling epithelial ovarian cancers (1–3). Perineal use of talcum powder has been positively associated with ovarian cancer risk in a number of case-control studies (4–13), although the magnitude of the associations has been modest, with odds ratios ranging from 1.2 to 1.9, and not all results reached statistical significance (5,6,8). Despite this relative consistency among studies, the limited supporting biologic evidence, together with the possibility of recall and selection bias in case-control studies (1), has raised questions about the plausibility of the association. We, therefore, prospectively examined the relationship between perineal talc use and ovarian cancer risk in a large cohort of U.S. women.

## METHODS

The Nurses' Health Study, established in 1976, is a prospective cohort of 121 700 registered nurses living in 11 of the larger states in the United States. Questionnaires were mailed to married, female nurses aged 30–55 years, requesting information on health-related issues, including medical history and potential risk factors for cancer. Follow-up questionnaires have been mailed every 2 years to update information on exposures and to ascertain newly diagnosed diseases. The study was approved by the Human Research Committee at the Brigham and Women's Hospital, Boston, MA.

**Ascertainment of cases.** We sought medical records from all women who reported a diagnosis of ovarian cancer or who were deceased in each follow-up cycle. Records were reviewed by physicians unaware of exposure status. Histologic subtypes were determined from pathology reports, and epithelial ovarian cancers were classified as serous cancers (including cystadenocarcinoma and papillary adenocarcinoma), mucinous cancers (including adenocarcinoma and mucinous papillary adenocarcinoma), and endometrioid cancers (clear cell and other types, including mixed epithelial tumors). Borderline histologic tumors are included in the analysis. Deaths are reported by relatives and postal authorities, as well as a search of the National Death Index. Mortality follow-up is estimated to be 98% complete in this cohort (14). Cases of epithelial ovarian cancer (International Classification of Diseases Code, ICD183.0), confirmed by medical rec-

ord review or death certificate, occurring between the return of the 1982 questionnaire and June 1, 1996, were included in the analysis.

**Exclusions.** Women who did not respond to the question on talc use in 1982 were excluded from this analysis. We also excluded women who had reported a diagnosis of cancer (other than nonmelanoma skin cancer) before 1982, as well as women who reported bilateral oophorectomy, surgery with an unknown number of ovaries removed, and a history of radiation therapy. Validity of self-reported surgical menopause has been assessed previously, and agreement with medical records was more than 97% (15). These exclusions were updated every 2 years. At baseline, 78 630 women were eligible for the analysis. The resulting population after exclusions contributed 984 212 person-years of follow-up and 307 cases of epithelial ovarian cancer.

**Ascertainment of talc exposure.** Use of talcum powder was ascertained on the 1982 questionnaire in the following ways: "Have you ever commonly used talcum, baby powder, or deodorizing powder *a*) to apply to perineal (private) area? No, daily, one to six times per week, or less than once per week or *b*) to apply on sanitary napkins? No, Yes." We classified "ever talc use" as ever talc use on either the perineal area or sanitary napkins.

**Other covariates.** Potential risk factors and confounders of the association between ovarian cancer and exposures of interest in this analysis also were obtained from the biennial questionnaires and were updated every 2 years where relevant. Oral contraceptive use was asked every 2 years from 1976 through 1982, by which time use was rare. Tubal ligation history was asked as part of a question on methods of contraception from 1976 through 1984, and, in 1994, women were asked if they had ever

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had a tubal ligation and, if so, at what age. Family history of ovarian cancer was not asked until 1992. Parity was defined as the number of pregnancies lasting 6 months or more and was asked through 1984.

**Statistical analysis.** Incidence rates (number of cases for each category of exposure divided by person months of follow-up in that cycle) were calculated for each category, adjusting for age in 5-year intervals. Proportional hazards models by use of pooled logistic regression were used to derive relative risks (RRs) and 95% confidence intervals (CIs) of disease for each exposure category (16). For age-adjusted analyses, we categorized variables as follows: parity (0, 1–2, or  $\geq 3$ ), oral contraceptive use (never, past, or current), tubal ligation (yes or no), postmenopausal hormone use (never, past, or current), cigarette smoking (never, past, or current), and body mass index, i.e., weight in kilograms/height in meters squared ( $<21$ , 21.0–22.9, 23.0–24.9, 25.0–28.9, or  $\geq 29$  kg/m<sup>2</sup>). In multivariate analyses, we adjusted for age (years) and for potential risk factors by use of indicator variables for each category as described above, except for parity (0, 1–2, 3–4, or  $\geq 5$ ) and duration of oral contraceptive use (never or  $<3$ , 3–5, or  $>5$  years), for which we used a larger number of categories to more appropriately control for confounding. In addition we controlled for age at menarche, duration of breast-feeding, and age at menopause. However, since this did not alter the estimates for talc use, further models did not control for these variables. Body mass index and duration of oral contraceptive use were also entered as continuous variables, and similar estimates were obtained. All RRs reported are multivariate unless otherwise stated. *P* values reported are two-sided.

## RESULTS

Three hundred seven women developed ovarian cancer in the cohort from 1982 through 1996 who responded to the 1982 questionnaire on talc use. In 1982, 40.4% ( $n = 31\,789$ ) of the baseline cohort reported ever using talc, of which 14.5% ( $n = 11\,411$ ) were ever daily talc users. Talc use was associated with higher body mass index and inversely associated with current cigarette smoking (Table 1).

We did not observe an overall association with ever use of talc and epithelial ovarian cancer (RR = 1.09; 95% CI = 0.86–1.37). There was also no elevation in risk among daily users of perineal talc, and no trend was seen with increasing frequency of use (Table 2). Talc use on sanitary napkins was inversely related to ovarian cancer, but the association was statistically nonsignificant. Exclusion of use of talc on sanitary napkins from the ever use of talc variable did not substantially alter the results. We also evaluated the risk for women who used both perineal talc and talc on sanitary napkins but did not see an effect compared with never users of talc (RR = 0.90; 95% CI = 0.59–1.37).

When we stratified by histologic sub-

**Table 1.** Age-standardized prevalence of ovarian cancer risk factors according to perineal talc use in 1982\*

	Ever perineal talc use, % <sup>†</sup> ( $n = 31\,789$ )	No perineal talc use, % ( $n = 46\,841$ )
Parity		
0	6.3	6.4
1–2	35.0	35.2
$\geq 3$	58.7	58.4
Oral contraceptive use		
Current	0.5	0.6
Past	49.2	49.8
Never	50.4	49.6
Hormone use, postmenopausal women only		
Current	12.1	12.9
Past	20.5	20.4
Never	67.4	66.7
Tubal ligation, yes	17.6	17.6
Cigarette smoking		
Never	44.9	43.2
Past	30.3	28.3
Current	24.9	28.5
Body mass index quintiles, kg/m <sup>2</sup>		
$<21.0$	16.0	22.1
21.0–22.9	20.9	25.4
23.0–24.9	20.1	20.6
25.0–28.9	22.8	19.6
$\geq 29$	19.8	12.0

\*Numbers do not always add up to 100% because of missing data or rounding.

<sup>†</sup>Ever talc use coded as either talc use on perineal area or talc use on sanitary napkins.

**Table 2.** Talc use and ovarian cancer: 1982 through 1996 (all subtypes included)\*

	No. of cases	Person-years	Age-adjusted RR (95% CI)	Multivariate RR <sup>†</sup> (95% CI)
Talc use on perineum				
Never	186	608 020	1.0 (referent)	1.0 (referent)
$<1$ /wk	43	128 923	1.10 (0.79–1.53)	1.14 (0.81–1.59)
1–6/wk	30	105 186	0.95 (0.65–1.40)	0.99 (0.67–1.46)
Daily	48	142 083	1.09 (0.79–1.49)	1.12 (0.82–1.55)
Talc use on sanitary napkins				
No	242	781 421	1.0 (referent)	1.0 (referent)
Yes	32	111 399	0.89 (0.62–1.29)	0.89 (0.61–1.28)
Ever perineal talc use				
No	179	586 758	1.0 (referent)	1.0 (referent)
Yes	128	397 454	1.05 (0.84–1.32)	1.09 (0.86–1.37)
Talc use, perineal and sanitary napkins				
None	179	586 758	1.0 (referent)	1.0 (referent)
Either talc use on perineum or use on sanitary napkins	103	307 317	1.11 (0.87–1.41)	1.15 (0.90–1.46)
Use on both sanitary napkins and perineum	25	90 137	0.89 (0.58–1.35)	0.90 (0.59–1.37)

\*RR = relative risk; CI = confidence interval.

<sup>†</sup>Multivariate analyses control for age (years), parity (0, 1–2, 3–4, or  $\geq 5$ ), duration of oral contraceptive use (never or  $<3$  y, 3–5 y, or  $>5$  y), body mass index (body weight in kilograms/height in meters squared:  $<21$ , 21.0–22.9, 23.0–24.9, 25.0–28.9, or  $\geq 29$  kg/m<sup>2</sup>), tubal ligation history (yes or no), smoking status (never, past, or current), and postmenopausal hormone use (never, past, or current).

type, we observed a modest increase in risk for ever talc use for serous invasive cancers (RR = 1.40; 95% CI = 1.02–1.91) but not for all serous cancers (including borderline cancers), endometrioid cancers, or mucinous cancers (Table 3). For women who reported ever daily use

of talc, the RR of invasive serous cancer was 1.49 (95% CI = 0.98–2.26). The RRs for ever talc users of less than once per week and one to six times per week were 1.29 (95% CI = 0.81–2.04) and 1.49 (95% CI = 0.77–2.11), respectively (*P* for trend = .05).

**Table 3.** Talc use and ovarian cancer: 1982–1996 (by histologic subtype)\*

Histologic subtype	No. of cases	Person-years	Age-adjusted RR (95% CI)	Multivariate RR† (95% CI)
All serous cancers, ever perineal talc use				
No	101	586 771	1.0 (referent)	1.0 (referent)
Yes	84	397 459	1.23 (0.92–1.64)	1.26 (0.94–1.69)‡
Serous invasive cancers, ever perineal talc use				
No	84	586 771	1.0 (referent)	1.0 (referent)
Yes	76	397 459	1.33 (0.98–1.82)	1.40 (1.02–1.91)‡
Endometrioid cancers, ever perineal talc use				
No	26	586 771	1.0 (referent)	1.0 (referent)
Yes	16	397 459	0.91 (0.49–1.69)	0.91 (0.49–1.87)
Mucinous cancers, ever perineal talc use				
No	30	586 771	1.0 (referent)	1.0 (referent)
Yes	20	397 459	0.98 (0.56–1.73)	0.93 (0.53–1.66)

\*RR = relative risk; CI = confidence interval.

†Multivariate analyses controlling for age (years), parity (0, 1–2, or ≥3), oral contraceptive use (never or ever), and tubal ligation history (yes or no).

‡Multivariate analyses control for age (years), parity (0, 1–2, 3–4, or ≥5), duration of oral contraceptive use (never or <3 y, 3–5 y, or >5 y), body mass index (body weight in kilograms/height in meters squared: <21, 21.0–22.9, 23.0–24.9, 25.0–28.9, or ≥29 kg/m<sup>2</sup>), tubal ligation history (yes or no), smoking status (never, past, or current), and postmenopausal hormone use (never, past, or current).

Because the talc hypothesis depends on the ability of fibers to migrate up a patent genital tract to the ovaries, we evaluated the risk among women who had reported a tubal ligation and those who had not. Women who were ever talc users and had never had a tubal ligation were not at increased risk of epithelial ovarian cancer compared with women who had not used talc (RR = 0.97; 95% CI = 0.71–1.32). There was no evidence of heterogeneity of RRs between women who had a tubal ligation and women who did not. In addition, when women who had had a tubal ligation or simple hysterectomy were excluded from the analysis, the RR for ever talc use was 1.15 (95% CI = 0.89–1.49). For serous invasive cancers, the RR for women who had never had a tubal ligation was similar to that for women without a tubal ligation; however, the number of case patients who had had a tubal ligation was small (data not shown).

Cosmetic talc may have been more likely to contain asbestos fibers prior to 1976, before voluntary guidelines were proposed (9). As a proxy for early talc use, we assessed risk among women 45 years old or older in 1982. There was no evidence that older women in 1982 were at greater risk of ovarian cancer overall; the RR for ever talc use compared with never talc use for women under 45 years was 0.95 (95% CI = 0.59–1.53) and among women 45 years old or older was 1.13 (95% CI = 0.86–1.47). However, women 45 years old or older in 1982 who

ever used talc had a higher risk of serous invasive cancer (RR = 1.51; 95% CI = 1.07–2.15). There was no evidence of effect modification by oral contraceptive use, body mass index, or cigarette smoking for epithelial cancers overall.

## DISCUSSION

To our knowledge, this is the first prospective analysis of talc use and ovarian cancer, and it addresses some of the potential limitations of previous case-control studies. Because we ascertained talc exposure prior to case diagnosis, the possibility for recall bias, which has been raised as a potential explanation for previous positive findings in case-control studies (1), is eliminated, and selection bias is reduced. We controlled for known or suspected ovarian cancer risk factors in the analysis, such as parity, oral contraceptive use, tubal ligation history, and body mass index, reducing the potential for uncontrolled confounding.

However, there are several important limitations to our study. The questions on talcum powder use referred to ever use, and we cannot determine the age at which women began using talc or the duration of use. Thus, we were unable to assess the potential effect of talc use before first pregnancy, which has been shown to be a stronger risk factor for ovarian cancer than use after pregnancy in one study (13). The number of lifetime applications of talc has also been associated with increased risk of ovarian cancer in some

previous studies (9,13). Our relatively short follow-up period may be inadequate to detect an association if the latency for development of ovarian cancer is more than 15 years. Although we controlled for tubal ligation history, the tubal ligation question was asked as part of a question on contraceptive use; therefore, postmenopausal women and some premenopausal women who were not sexually active may not have responded to the question. Substantial residual confounding is unlikely, since there was no overall association between talc use and tubal ligation in this study. In addition, we excluded women who were postmenopausal in 1976 from analyses stratified by tubal ligation history. Finally, the prevalence of talc use in our study is somewhat higher than that in other studies and may reflect the fact that we asked about frequency of ever use rather than current regular use; this may have contributed to an attenuation of risk due to misclassification of exposure.

The potential effect of talc on the ovaries depends on migration of talc fibers through a patent genital tract, and we would, therefore, expect a stronger association among women without a tubal ligation who had used talc. However, no effect modification was seen by history of tubal ligation. Because we did not have the date of tubal ligation, some women may have begun talc use only after tubal ligation, potentially resulting in misclassification of talc use and attenuation of the RRs.

Since the first study showing an almost twofold increase in risk of ovarian cancer with any perineal talc use (4), most case-control studies have demonstrated positive associations with talc use (4–13), although not all have been statistically significant (5,6,8). Several studies (9,17–20) found no overall association between any genital talc use and ovarian cancer. We did not observe a dose-response relationship with talc use, and previous studies also have been inconsistent in this regard. Some studies (9,13,17) have demonstrated statistically insignificant trends in risk with increased frequency of talc use, duration of use, and measures of “total lifetime applications,” while other studies (6,8) have not observed a statistically significant dose response.

With regard to histologic subtypes, a recent study by Cramer et al. (13) observed the greatest risk for talc use and invasive serous cancer; however, other



studies found increased risks for endometrioid cancers (9,12), serous cancers (7), and invasive cancers of all subtypes (12). Since serous cancers, which account for more than half of all invasive ovarian cancers, most resemble mesotheliomas, it could be hypothesized that this subtype may be most likely associated with talc use. In our stratification by subtype, we did observe a modest positive association with serous invasive cancers and ever talc use as well as a borderline significant trend for increasing frequency of ever use.

The biologic evidence for the association of talc and ovarian cancer is incomplete. Asbestos has been linked to ovarian cancer in occupational settings and is associated with peritoneal tumors similar to ovarian cancer (2,3,21). Because of the chemical similarity of talc and asbestos, talc also has been implicated as a possible ovarian carcinogen. Talc is able to migrate through the genital tract and gain access to the ovaries because talc fibers have been detected in benign and malignant ovarian tissue (22), although no relation between reported levels of talc exposure and ovarian talc counts has been observed (23). There have been few studies (24,25) of talc exposure in animals, and these studies have not demonstrated an increase in ovarian cancer among animals subjected to chronic talc exposure. These data should be interpreted cautiously because there are important anatomic and physiologic differences between rodents and humans, and talc in animals is often administered at high dose via aerosol exposure (24).

In summary, we did not observe an overall association between epithelial ovarian cancer and ever use of talc, and there was no apparent dose response, although we lacked information on duration of talc use. In analyses stratified by histologic subtype, we observed a modest positive association between invasive serous cancer and ever talc use. Our results provide little support for any substantial association between perineal talc use and

ovarian cancer risk overall; however, perineal talc use may modestly increase the risk of invasive serous ovarian cancers.

## REFERENCES

- (1) Harlow BL, Hartge PA. A review of perineal talc exposure and risk of ovarian cancer. *Regul Toxicol Pharmacol* 1995;21:254-60.
- (2) Keal E. Asbestosis and abdominal neoplasms. *Lancet* 1960;2:1211-6.
- (3) Acheson ED, Gardner MJ, Pippard EC, Grime LP. Mortality of two groups of women who manufactured gas masks from chrysotile and crocidolite asbestos: a 40 year follow-up. *Br J Indust Med* 1982;39:344-8.
- (4) Cramer DW, Welch WR, Scully RE, Wojciechowski CA. Ovarian cancer and talc: a case-control study. *Cancer* 1982;50:372-6.
- (5) Chen Y, Wu PC, Lang JH, Ge WY, Hartge P, Brinton LA. Risk factors for epithelial ovarian cancer in Beijing, China. *Int J Epidemiol* 1992;21:23-9.
- (6) Whittemore AS, Wu ML, Paffenbarger RS Jr, Sarles DL, Kampert JB, Grosser S, et al. Personal and environmental characteristics related to epithelial ovarian cancer. II. Exposures to talcum powder, tobacco, alcohol, and coffee. *Am J Epidemiol* 1988;128:1228-40.
- (7) Cook LS, Kamb ML, Weiss NS. Perineal powder exposure and the risk of ovarian cancer. *Am J Epidemiol* 1997;145:459-65.
- (8) Booth M, Beral V, Smith P. Risk factors for ovarian cancer: a case-control study. *Br J Cancer* 1989;60:592-8.
- (9) Harlow BL, Cramer DW, Bell DA, Welch WR. Perineal exposure to talc and ovarian cancer risk. *Obstet Gynecol* 1992;80:19-26.
- (10) Purdie D, Green A, Bain C, Siskind V, Ward B, Hacker N, et al. Reproductive and other factors and risk of epithelial ovarian cancer: an Australian case-control study. *Int J Cancer* 1995;62:678-84.
- (11) Shushan A, Paltiel O, Iscovich J, Elchalal U, Peretz T, Schenker J. Human menopausal gonadotropin and the risk of epithelial ovarian cancer. *Fertil Steril* 1996;65:13-8.
- (12) Chang S, Risch HA. Perineal talc exposure and risk of ovarian carcinoma. *Cancer* 1997;79:2396-401.
- (13) Cramer DW, Liberman RE, Titus-Ernstoff L, Welch WR, Greenberg ER, Baron JA, et al. Genital talc exposure and risk of ovarian cancer. *Int J Cancer* 1999;81:351-6.
- (14) Stampfer MJ, Willett WC, Speizer FE, Sysert DC, Lipnick R, Rosner B, et al. Test of the National Death Index. *Am J Epidemiol* 1984;119:837-9.
- (15) Hankinson SE, Hunter DJ, Colditz GA, Willett WC, Stampfer MJ, Rosner B, et al. Tubal ligation, hysterectomy, and risk of ovarian cancer. *JAMA* 1993;270:2813-8.
- (16) D'Agostino RB, Lee ML, Balanger AJ, Cupples LA, Anderson K, Kannel WB. Relation of pooled logistic regression to time dependent Cox regression analysis: the Framingham Heart Study. *Stat Med* 1990;9:1501-15.
- (17) Hartge P, Hoover R, Leshner LP, McGowan L. Talc and ovarian cancer [letter]. *JAMA* 1983;250:1844.
- (18) Rosenblatt KA, Thomas DB. Lactation and the risk of epithelial ovarian cancer. The WHO Collaborative Study of Neoplasia and Steroid Contraceptives. *Int J Epidemiol* 1993;22:192-7.
- (19) Tzonou A, Polychronopoulou A, Hsieh CC, Rebelakos A, Karakatsani A, Trichopoulos D. Hair dyes, analgesics, tranquilizers and perineal talc application as risk factors for ovarian cancer. *Int J Cancer* 1993;55:508-10.
- (20) Wong C, Hempling RE, Piver MS, Natarajan N, Mettlin CJ. Perineal talc exposure and subsequent epithelial ovarian cancer: a case-control study. *Obstet Gynecol* 1999;93:372-6.
- (21) Wignall BK, Fox AJ. Mortality of female gas mask assemblers. *Br J Indust Med* 1982;39:34-8.
- (22) Henderson WJ, Joslin CC, Turnbull AC, Griffiths K. Talc and carcinoma of the ovary and cervix. *J Obstet Gynecol* 1971;78:266-72.
- (23) Heller DS, Westhoff C, Gordon RE, Katz N. The relationship between perineal cosmetic talc usage and ovarian talc particle burden. *Am J Obstet Gynecol* 1996;174:1507-10.
- (24) Boorman GA, Seely JC. The lack of an ovarian effect of lifetime talc exposure in F344/N rats and B6C3F1 mice. *Regul Toxicol Pharmacol* 1995;21:242-3.
- (25) Hamilton TC, Fox H, Buckley CH, Henderson WJ, Griffiths K. Effects of talc on the rat ovary. *Br J Exp Pathol* 1984;65:101-6.

## NOTES

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